NEW JERSEY STATE DENTAL BENEFITS APPLICATION	LICATION • Division of Pensions and Benefits • P.O. Box 299							Effective Date: Event Reason:
HD-0081-0501	• Trenton, NJ • 08625-0299							Lifective Date.
$\textbf{1. EMPLOYEE INFORMATION} - \textbf{This section must be filled out } \textit{completely}. \ \textbf{Please partial}$	2. TYPE OF COVERAGE							
Social Security Number  Last Name Title (Jr., Sr., etc.)  First Name MI  Street Address (Include Apartment #)  City State  Zip Code + 4 Date of Birth (mm/dd/yy) Gender (M/F)  Marital Status: - Single - Married - Divorced - Widowed  (Area Code) Home Telephone Number from another SHBP participating employer?  No  If yes, name of employer			Select one Single Family Member & Spouse Parent & Child(ren)  3. Employee Selection Change Plan from to I wish to be covered under the Dental Expense Plan (Traditional) I wish to be covered under a Dental Plan Organization (DPO)  Name of DPO DPO#  Name and Address of Dental Provider  I elect to waive dental coverage.					EMPLOYER CERTIFICATION To Be Completed By Employer Employer Name:
								Payroll # 10/12 Month  (State Biweekly) Employee  Location # (State Monthly Only)  Location # (State Monthly Only)  MEMBER ACTION:  New Enrollment  Date Employment  Began (Mo/Day/Yr)/
4. SPOUSE AND CHILDREN INFORMATION — List only eligible dependents. NOTE employee.  Spouse - Last Name  First Name	: Your depende	ents may	not be c	overed I	•		•	ate Dental Program Plan as either a dependent or  accurity Number  Natural (C) Adopted (A) Foster (F) Step (S)
Children								
Former Name  Birth of Child - Date (Mo/Day/Yr)  Adoption/Guardianship - Proof Required Date (Mo/Day/Yr)  B. DELETION OF DEPENDENT  Separation - Date (Mo/Day/Yr)  Divorce - Date (Mo/Day/Yr)  Death of Spouse/Child - Date (Mo/Day/Yr)  Deletion of Child  Give Reason  C. OTHER C  C. OTH	s SSN	only  # (Attach  (Attach  Dellow (i.e.	copy of & copy of	Social So	ecurity care ertificate)	true to the be State Health I able to alter t of dependents months (26 bi in a Dental PI I have select State Dental I ant to the cor named Denta dentist's offici in the contract by dental ser terminates pa participting in any informatio	est of my knowledge Benefits Commission he coverages I have and must remain a sweekly pay periods) lan Organization, I used a dentist or face Program. I understantract of which this at I Plan Organization or facility which I st. I understand that vice providers in that it is a same DPO. I at the same DPO. I are relating to service	tify that all the information supplied on this form is e. I authorize a salary deduction as required by the n and my employer. I understand that I will not be e selected except for changes in status or eligibility participant of this program for a minimum of twelve o as long as I remain eligible for coverage. If I enroll understand that it is my responsibility to ensure that illity associated with that DPO participating in the and and agree that the benefits and services pursuapplication is a part are to be rendered only by the n as indicated on this application and only at the have designated above, or as otherwise provided to there is no guarantee of continuous participation the DPO programs. If my dentist or dental facility DPO of my choice, I must select another provider authorize my attending dentist or facility to release as rendered to me or my dependents to the DPO or
Give United's Name						Employee's Sig	gnature	Date Completed

# COMPLETING THE NJ STATE DENTAL BENEFITS PROGRAM APPLICATION QUICK REFERENCE

- To **enroll** for the first time complete all sections of the application.
- To **change dental plans** complete sections: 1, 2, and 3 (if enrolling in a DPO be sure to list the name and address of your dental provider), 4 (listing all eligible dependents), 5, and 6.
- To **change coverage level** (adding/deleting dependents) complete sections: 1, 2, and 3, 4 (be sure to list all eligible dependents), 5 (listing why you are changing coverage level), and 6.
- To add a dependent complete sections: 1, 2, 3, 4 (be sure to list all eligible dependents), 5, and 6.
- To terminate/decline coverage complete sections: 1, 3, and 6.

#### **SECTION 1 — EMPLOYEE INFORMATION**

This section must be completed in its entirety each time an application is submitted. The employee enrolling or enrolled in the plan completes this section.

## **SECTION 2 — TYPE OF COVERAGE**

2. If you are electing coverage, check the coverage level desired.

#### **SECTION 3 — EMPLOYEE SELECTION**

3. Check only one box indicating in which plan you wish to be enrolled. If you are enrolling in a Dental Plan Organization (DPO) list the name and address of your dental provider. If you do not want dental coverage or wish to cancel coverage, check the appropriate. NOTE, once you decline or cancel coverage, enrollment is not normally permissible until the next open enrollment period.

#### **SECTION 4 — SPOUSE AND CHILDREN**

Only eligible dependents may be listed. Completion of this section is essential for proper enrollment. Be sure dependents listed agree with level of coverage elected in section 2. List the name, date of birth, gender, and Social Security number of the family members you wish to be covered under the plan. An eligible spouse is an individual to whom you are legally married. If you have listed a child that is a foster or stepchild or has a different last name than the employee, contact your payroll/personnel representative for instructions regarding required documentation. If you have more than 4 eligible dependent children, attach a separate application and completed Sections 1, 4, and 6. If you are deleting dependents, do not list them in this section. Refer to section 5c.

# **SECTION 5 — TYPE OF ACTIVITY**

- **5a.** If you are adding a dependent, check the appropriate box and list the event date.
- **5b.** If you are deleting a dependent, check reason and indicate the event date.
- 5c. Check the appropriate box when making other changes.

# **SECTION 6 — EMPLOYEE CERTIFICATION**

You must read the Employee Certification statement, sign it, and date the application.

### **EMPLOYER CERTIFICATION**

Must be completed by your employer.